CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE
POLYSOMNOGRAPHY ADVISORY COUNCIL

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A POLYSOMNOGRAPHER
INSTRUCTION SHEET

Read all instructions carefully before completing and submitting your application. If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Selecting Type of Application

The documentation that you are required to submit in support of your application depends in part on the type of application you file. Use the following guidelines to decide which type of application you should select:

- ***Endorsement*** – Select this type if you meet ***both*** of these conditions:
  - You hold a *current* license to practice polysomnography in another jurisdiction (state, U.S. territory or District of Columbia), ***and***
  - There are no outstanding or unresolved complaints against you.

  If you do not meet both conditions, select another application type.

  The Council will review the laws and regulations of the other jurisdictions where you hold a current polysomnographer license to determine if any has licensure requirements that are substantially similar to Delaware's requirements. If any jurisdiction's licensure requirements are substantially similar to those of Delaware, you may be licensed by endorsement. However, if the Council determines that none of the jurisdictions has substantially similar requirements, you cannot be licensed by endorsement and must instead meet the requirements for either *Original License* or *Current Practitioner*.

- ***Current Practitioner*** – Select this type if you
  - are *currently* practicing polysomnography, ***and***
  - were practicing as of July 1, 2011.

  Even if you are currently practicing, you must choose another type if you were not practicing as of July 1, 2011.

- ***Original License*** – Select this type if neither description above applies to you.

Requirements for *All* Applicants

The following summarizes the documentation requirements for all applicants, regardless of the type of application you are filing. The application form may request additional documentation based on your answers to the questions.

☐ Submit completed, signed and notarized *Application for Licensure as a Polysomnographer* form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."
- Applications submitted without this processing fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
- This is required *even if* you recently had a criminal background check done for some other reason.

☐ Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.

☐ You must submit proof that you have passed a national certifying examination, as follows:

IF you are applying by…	**THEN** arrange for the Council office to receive verification that…
Current Practitioner	• You have passed the Certified Polysomnographic Technician (CPSGT) or Registered Polysomnographic Technologist (RPSGT) examination given by the Board of Registered Polysomnographic Technologists (BRPT), sent directly from BRPT to the Council office, ***and*** • You have been certified by the BRPT.
Endorsement	You have passed ***either*** the: • Certified Polysomnographic Technician (CPSGT) or Registered Polysomnographic Technologist (RPSGT) examination given by the Board of Registered Polysomnographic Technologists (BRPT), ***or*** • Sleep Disorders Specialty (SDS) examination given by the National Board for Respiratory Care (NBRC).
Original License	

- The verification must be sent *directly* to the Council office from the organizations:
  - To request BRPT verification, see BRPT's web site (www.brpt.org).
  - To request NBRC verification, see NBRC's web site (www.nbrc.org).

☐ If you have ever been licensed to practice polysomnography in another jurisdiction, arrange for the Council office to receive a license verification (i.e., letter of good standing) sent *directly* from *each* jurisdiction where you have ever held a polysomnography license.
- Internet or faxed verifications will not be accepted because the state seal must be affixed to the document.

☐ Submit a certificate showing that you have completed a current Basic Life Support (BLS) course that includes *hands-on* skills training.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirement for *Endorsement* Applicants

The following is required in addition to the items listed in **Requirements for *All* Applicants** above.

☐ Submit copies of the licensing/practice statutes and regulations pertaining to the practice of polysomnography from each jurisdiction where you hold a current license.
- The Council will determine whether the licensing requirements of any jurisdiction where you are currently licensed are at least equal to those of Delaware. If none is at least equal, you must meet the requirements in either **Additional Requirements for *Current Practitioner* Applicants** or **Additional Requirements for *Original Licensure* Applicants** below because you cannot be licensed by endorsement.

Additional Requirements for *Current Practitioner* Applicants

The following is required in addition to the items listed in **Requirements for *All* Applicants** above.

☐ Submit proof that you were practicing as a polysomnographer as of July 1, 2011:
- If you were employed, provide Form W-2.
- If you were self-employed, provide Schedule C of your tax return, business license, or similar documentation acceptable to the Council.

Additional Requirements for *Original License* Applicants

The following is required in addition to the items listed in **Requirements for *All* Applicants** above.

☐ Arrange for the Council office to receive verification that you have completed ***one*** of the following approved educational programs. Verification must be sent *directly* from the organization to the Council office.

- A polysomnographic educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs (www.caahep.org) ***or***
- A respiratory care educational program that is accredited by the Committee on Accreditation for Respiratory Care and completion of the curriculum for polysomnography certificate established and accredited by the Committee on Accreditation for Respiratory Care (www.coarc.com) ***or***
- An electroneurodiagnostic technologist educational program with a polysomnographic technology track that is accredited by the Commission on Accreditation of Allied Health Education Programs (www.caahep.org) ***or***
- An Accredited Sleep Technologist Educational Program (A-STEP) that is accredited by the American Academy of Sleep Medicine (www.aasmnet.org) ***or***
- Any other educational program incorporating both formal instruction and supervised clinical practice as recommended by the Council and approved by the Board of Medical Licensure and Discipline.

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GENETIC COUNSELOR ADVISORY COUNCIL

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APPLICATION FOR LICENSURE AS A POLYSOMNOGRAPHER

TYPE OF APPLICATION – *All* applicants complete this section.

1. Select the type of application you are filing (check one):

   ☐ Endorsement – I hold a *current*, *active* license to practice polysomnography in another jurisdiction (state, U.S. territory or District of Columbia) ***and*** I do not have any outstanding or unresolved complaints against me.

   ☐ Current Practitioner – I am *currently* practicing polysomnography ***and*** was practicing as of July 1, 2011.

   Submit proof that you were practicing as a polysomnographer as of July 1, 2011:
   - **If you were employed, provide Form W-2.**
   - **If you were self-employed, provide Schedule C of your tax return, business license, or similar documentation acceptable to the Council.**

   ☐ Original License – Check this if neither type above applies to you.

IDENTIFYING AND CONTACT INFORMATION – *All* applicants complete this section.

2. Full Name: _____ _____ _____
   Last First Middle

3. Other Names Used: _____ _____ _____
   Include maiden, former married, alternate spellings.

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Address: _____

   _____ _____ _____
   City State Zip

7. Phone: _____ _____ Email: _____
   daytime or cell fax

EDUCATION – *Only* applicants for Original License complete this section.

8. Enter the following information about your polysomnography educational program. See Instruction Sheet for list of approved programs.

INSTITUTION	LOCATION	DATES ATTENDED		DEGREE
		From	To	

Arrange for the Council office to receive verification that you have completed the program(s) listed above, sent *directly* from the school to the Council office.

EXAMINATION AND CERTIFICATION INFORMATION – *All* applicants complete this section.

9. Have you passed one of the following national certifying examinations? Yes ☐ No ☐ If yes, check the examination you have passed:

   ☐ Certified Polysomnographic Technician (CPSGT)

   ☐ Registered Polysomnographic Technologist (RPSGT)

   ☐ Sleep Disorders Specialty (SDS)

   - The CPSGT and RPSGT are given by the Board of Registered Polysomnographic Technologists (BRPT).
   - The SDS is given by the National Board for Respiratory Care (NBRC).

   - **If applying by Endorsement or Original License, arrange for the Council office to receive verification, sent *directly* from the organization, that you have passed the CPSGT, RPSGT, or SDS.**
   - **If applying as a Current Practitioner, arrange for the Council office to receive verification, sent *directly* from BRPT, that you have passed the CPSGT or RPSGT and are BRPT-certified.**

10. Do you hold a current Basic Life Support (BLS) certification? Yes ☐ No ☐

    Submit a certificate showing that you have completed a current Basic Life Support (BLS) course that includes *hands-on* skills training.

LICENSURE HISTORY – *All* applicants complete this section.

11. Have you ever had a polysomnographer license denied? Yes ☐ No ☐ **If yes, explain on a separate sheet and enclose it with this application. Also, enclose a copy of the order**.

12. Have you ever held a license as a polysomnographer in any jurisdiction (state, District of Columbia, or U.S. territory)? Yes ☐ No ☐ If yes, enter information about each license you have ever held. If you need more room, enclose a separate sheet.

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

   - **Arrange for the Council office to receive a license verification *directly* from *each* jurisdiction where you have ever held a polysomnographer license.**
   - **If applying by Endorsement, also submit copies of the licensing/practice laws and regulations pertaining to the practice of polysomnography from each jurisdiction where you hold a *current* license.**

DISCLOSURES – *All* applicants complete this section.

13. Have you ever been convicted or entered a plea of guilty or *nolo contendere* (no contest) to any felony or misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐

    Arrange for the Council office to receive State of Delaware and Federal Bureau of Investigation criminal background checks.

14. Are any criminal charges pending against you in any jurisdiction? Yes ☐ No ☐ **If yes, enclose a signed statement that explains fully.**

15. Have you ever been disciplined by a healthcare facility or any entity governing polysomnography licensure, including having a license revoked, suspended, limited or placed on probation? Yes ☐ No ☐ **If yes, enclose a signed statement that explains fully. Also, enclose a copy of the disciplinary order.**

16. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐ **If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question.** If no, skip to Question 18.

17. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes ☐ No ☐

18. Within the two years preceding this application, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a polysomnographer, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐ **If yes, enclose a signed statement that explains fully and continue with the next question.** If no, skip to the **DUTY TO REPORT** section.

19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐ **If yes, enclose a signed statement that explains fully.**

DUTY TO REPORT

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A and that I understand my *duty to report*. Yes ☐ No ☐

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to self report all of the following:
    - Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 *Del. C.* §1730(b)(1))
    - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 *Del. C.* §1730(b)(2))
    - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 *Del. C.* §1730 (c))
    - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 *Del. C.* §1731A (f))
    - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 *Del. C.* §1730 (d))
    - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 *Del. C.* §1730 (d))

    I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my *duty to self report*. Yes ☐ No ☐

    Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.

    To assure consideration of your license application at the next Council meeting, the Division must receive all of these items no later than 4:30 PM ten full working days before the Council's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within six months of filing may be considered abandoned and discarded. When your application is complete, allow 4-8 weeks to receive your permanent license (whether or not a provisional license has been issued).

AFFIDAVIT

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I further understand that by filing this application for a Polysomnographer in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Board of Medical Licensure and Discipline and Council's Rules and Regulations and to determine that I am physically and mentally capable of engaging in the practice of polysomnography with safety to the public.

I authorize the Council of the Board of Medical Licensure and Discipline and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

AUTHORIZATION FOR RELEASE OF INFORMATION

Please print or type all information in black ink.

Check the type of license for which you are applying:

☐ Adult Entertainment	☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)	☐ Psychology
☐ Deadly Weapons Dealer	☐ Nursing (RN, LPN, APN)	☐ Social Work
☐ Dental	☐ Nursing Home Administrator	☐ Real Estate Appraisers
☐ Massage	☐ Pharmacy	☐ Texas Hold'em Individual

☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

Print your current full name:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Fax or Mail Request to:

DSCYF, OCCL
Criminal History Unit
1825 Faulkland Road
Wilmington, DE 19805
Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed.**
- **Do not use a cover sheet.**
- **Do not send duplicate requests.**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed.**

PART I. APPLICANT INFORMATION – Type or print clearly.

Name: _____ _____ _____
Last First Middle

Other Name(s) Used: _____ _____ _____ DE Drivers License #: _____

Social Security #: _____ - ___ - _____ Date of Birth: ___ / ___ /_____ Sex: Male ☐ Female: ☐ Race: _____
mm / dd / yyyy

Address:_____ _____ _____ _____
Street City State Zip

Have you ever been involved in a substantiated case of child abuse or neglect? Yes ☐ No ☐ If Yes, explain:

_____

_____

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature:_____ Date:_____

Parent or Guardian Signature if applicant is under the age of 18: _____

PART II. AGENCY/ORGANIZATION INFORMATION

Please check only one:

☐ EDUCATION ☐ HEALTH CARE FACILITY ☐ CHILD CARE ☒ OTHER: State Agency

Agency Identification Number (if applicable): 1179
Requesting Agency Name: **Division of Professional Regulation**
Address: Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904
Phone: (302) 744-4500 Fax: (302) 739-2711 Contact Person: Nicole Williams

DSCYF USE ONLY

The individual listed above (___ is listed) (___ is NOT listed) on the Delaware Child Protection Registry.

Date: _____ DSCYF Criminal History Unit _____

Created 1/2014